MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08908

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 14 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new born infants give residence of mother)
State Md County
City or town Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Charles N. Baltzell

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Widowed

B (b) Name of husband or wife Alice Hyde Baltzell

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13 1869

8. AGE:

Years	Months	Days	If less than one day
77	10	7	hrs. min.

9. Birthplace Thurmont Frederick Co Md
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Stone cutter
FATHER 12. Name Jessie Baltzell
13. Birthplace Thurmont
MOTHER 14. Maiden name Unknown
15. Birthplace "
16. Informant Mrs Howard Sensenney
Address Westminster Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 23-47 (month) (day) (year)
Cemetery or crematory W. B. Cemetery
Location Thurmont Md
18. Funeral director M. L. Crouse Sons
Address Thurmont Md
19. 10/22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 20 1946 to Oct 21 1947
and that I last saw him alive on Oct 19 1947

Immediate cause of death	DURATION
Myocardial degeneration	6 mos
Due to Arteriosclerosis	3+ yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C Reese Wilkens M. D. or other
Address Westminster Date signed 10/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08309

93d

Reg. Dist. No. 75

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester Md Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 mo.
Hospital, institution, or street address where death occurred:
New Melrose md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester Md Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: New Melrose
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Kate Bankert.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Augustus Bankert. 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1874

8. AGE: Years 73 | Months 7 | Days 6 | If less than one day: hrs. min.

9. Birthplace: Backsmans Valley, Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Joseph Sipsey
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Caroline Bayne
15. Birthplace: Maryland

16. Informant: Mrs Chester Gehman
Address: Manchester, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 9 1947 (month) (day) (year)
Cemetery or crematory: Trinders Cemetery Westminster
Location:

18. Funeral director: W. A. Feaser
Address: Hanover Pa.

19. Oct 8 1947 (Date rec'd by registrar) Mrs. W. R. P. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1947 at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1936 to Oct 7 1947 and that I last saw h.. alive on October 7 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: 24 hrs

Due to: Hypertensive Cardio-Vascular Disease

Due to:

Other conditions: Generalized Arteriosclerosis?

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work?

23. SIGNATURE: Joseph E. Burch M.D. M. D. or other

Address: Hampstead Md Date signed: 10-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08910

131b

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 0 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rurel, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lydia C. Basler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife J. Jacob Basler

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Oct. 25 — 1870

8. AGE:

Years	Months	Days	If less than one day
76	11	28	hrs. min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Andrew Drechsler

13. Birthplace Germany

MOTHER 14. Maiden name Angeline Long

15. Birthplace Carroll Co. Md.

16. Informant J. Jacob Basler

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25 - 1947 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 10 24 1947 (Date rec'd by registrar) H. C. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1947, at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1944, to October 23 1947

and that I last saw h.. alive on October 22 1947

Immediate cause of death	DURATION
Myocarditis (chr.)	?
Hypertin (chr.)	?
Due to	
Due to	
Other conditions Senile coma	5 days

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D. M. D. or other

Address Westminster 2d Date signed 10-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08911

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months, 23 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 9 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9018 Sudbury Road
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Bertha May Bendure

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Aubrey Bendure

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 14, 1880

8. AGE: Years	Months	Days	If less than one day
67	6	20	..... hrs. ..... min.

9. Birthplace: New Cumberland, W.Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Laurence Andrews
13. Birthplace: New Cumberland, W.Va.

MOTHER — 14. Maiden name: Anna E. McConnell
15. Birthplace: New Cumberland, W.Va.

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-8-47 (month) (day) (year)

Cemetery or crematory: North Canton

Location: North Canton, Ohio

18. Funeral director: C. Harry Wee

Address: Sykesville, Md.

19. Oct. 5 1947 (Date rec'd by registrar) C. Harry Wee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4, 1947, at 3.00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9, 1947, to October 4, 1947 and that I last saw her alive on October 4, 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	6 weeks
Due to: Cerebral arteriosclerosis	about 2 years
Due to:	
Other conditions: Psychosis with cerebral arterio sclerosis	about 18 months

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Irene Hohman M.D

Springfield State Hospital M. D. or other

Address ..... Date signed 10-4-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 7789 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: J Milton Benson

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Delia Benson
6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): aug 21 - 1862

8. AGE: Years	Months	Days	If less than one day
85	1	16	hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Retired farmer
11. Industry or business
FATHER 12. Name: Jesse Benson
13. Birthplace: Md
MOTHER 14. Maiden name: Araetta Amacost
15. Birthplace: Md
18. Informant: Mrs J M Benson
Address: Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10/47 (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Baltimore Md
18. Funeral director: Edw A Tipton
Address: Hampstead Md
19. Oct 7 1947 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7 1947, at 4:07 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1940, to Oct 7 1947
and that I last saw him alive on Oct 5 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	1 mo
Due to: Coronal Arterio-Sclerosis	3 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maurice E. Pentzfeld M. D. or other
Address: Hampstead Md Date signed: 10-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08913

932

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 1 mo. 10 da.
Hospital, Institution, or street address (if not in hospital): Springfield State Hospital
How long in hospital or institution? 1 yr. 1 mo. 10 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2828 Harwiew Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Theresa Bodecker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced.
F	W	Widowed

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct 23 - 1875

8. AGE: Years: 71 | Months: 11 | Days: 20 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Pa
(Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business: —

FATHER — 12. Name: Henry Bodecker
13. Birthplace: Germany

MOTHER — 14. Maiden name: Juliana Bodecker
15. Birthplace: Germany

16. Informant: William Bodecker
Address: 2528 Fairview Ave Baltimore

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: 10/14/47 (month) (day) (year)

Cemetery or crematory: Pittsburgh Pa.

Location: —

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. Oct 13 1947 (Date rec'd by registrar) A. Harry Ware Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 13th 1947 at 4-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28th 1946 to Oct 13th 1947 and that I last saw her alive on Oct 13th 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Cardiac Hypertrophy	5 yrs
Due to: Sent. Arteri-Sclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

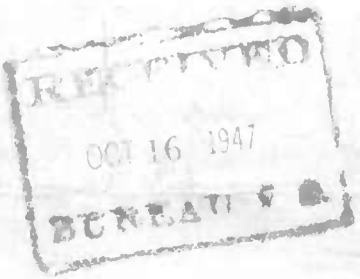
23. SIGNATURE: W. W. Gaston M.D.
M. D. or Coroner
Address: Sykesville Md. Date signed: 10/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The color of age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15 9-45-15M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OCT 16 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08915

930

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:
County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Irene S Buchman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband ~~or wife~~ Thomas W Buchman
6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) June 22-1871

8. AGE: Years 76 | Months 3 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William A Davidson
13. Birthplace Md

MOTHER
14. Maiden name Susanna Hoffman
15. Birthplace Md

16. Informant Thos W Buchman
Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15 47 (month) (day) (year)
Cemetery or crematory Wesley
Location Carroll Co Md

18. Funeral director Edw Tipton
Address Hampstead, Md

19. Oct. 14 1947 (Date rec'd by registrar) John S. Highad Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1947, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20 1943, to Oct 12 1947 and that I last saw h... alive on Oct 12 1947

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to Hypertensive Cardio-Vascular Disease.	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph E. Buck M.D. M. D. or other
Address Hampstead md Date signed 10-12-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

08914

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 83 yrs 7 mos 13 ds

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 69 John

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Glenn Theodore Buckingham

3.(b) Social Security Number 212-14-8904

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Elizabeth Buckingham

6.(c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) March 10 - 1863

8. AGE: Years	Months	Days	If less than one day
82	7	13	hrs. min.

9. Birthplace Westminster, Md.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Elisha Buckingham

13. Birthplace Md.

MOTHER 14. Maiden name Margaret Buckingham

15. Birthplace Md.

16. Informant Mrs Mary Doyle

Address Londonderry, Balto. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29-1947 (month) (day) (year)

Cemetery or crematory St. Johns Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster Md.

19. 10/28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1947, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1946, to Oct 25 1947 and that I last saw him alive on Oct 25 1947

Immediate cause of death	DURATION
acute Cardiac Decompensation	8 hrs
Chronic Myocarditis	1 year
Due to Chronic Interstitial Nephritis	3 yrs
Due to Arteriosclerosis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. R Fouty M.D. (M. D. or other)

Address Westminster Md. Date signed 10-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170C 0891 82

Reg. Diat. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 629 S. Rappolla St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Jesse de Roy Butler

3.(b) Social Security Number 219-05-2209

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 26, 1912

8. AGE: Years	Months	Days	If less than one day
35	3	23	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Crane Operator

11. Industry or business: Bethlehem Steel Co.

FATHER — 12. Name: Jesse A. Butler

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sophia J. Grimm

MOTHER — 15. Birthplace: Maryland

18. Informant: Mrs. Sophia J. Butler

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 10-22-47 (month) (day) (year)

Cemetery ~~or crematory~~: Pine Grove

Location: Mt. Airy, Maryland

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. Oct 20 19 47 (Date rec'd by registrar) Wm D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19 1947 at 1:50 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Fractured Skull and Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10-19-47

Where did injury occur: Mt. Airy (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?): Route 27

Means of injury: Struck by automobile Injured at work? No

23. SIGNATURE: James T. Thomas, Deputy Medical Examiner M. D. or other

Address: Westminster, Md. Date signed: 10-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08917

930

CERTIFICATE OF DEATH

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Carroll
City or town: Gaither
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Gaither
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ZOLAND T. CARR

3.(b) Social Security Number: --None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Daisy Carr

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1902

8. AGE: Years 45 | Months 8 | Days 9 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Tenant

11. Industry or business: Springfield Hospital

FATHER 12. Name: Harry Carr

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Elizabeth Bloom

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs. Daisy Carr
Address: Gaither, Md.

17. Burial (Burial, ~~cremation, or removal. Which~~?) Date thereof 10-10-47 (month) (day) (year)
Cemetery ~~or crematory~~: Springfield
Location: Sykesville, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Oct 9 (Date rec'd by registrar) 19 47 Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 October 1947, at 4:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to 6 Oct 1947 and that I last saw h.i.m. alive on 6 October 1947

Immediate cause of death	DURATION
hypertensive cardiovascular disease with myocarditis	
Due to arteriosclerosis -	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. H. Lawrence M.D. M. D. or other
Address: Sykesville, Md. Date signed: 10/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08918

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos. 27 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5613 Crow Court
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Emma Carter

3.(b) Social Security Number: 220-14-3387

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Separated

6.(b) Name of husband or wife: Major Carter
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): December 25, 1912

8. AGE: Years	Months	Days	If less than one day
34	9	12	.....hrs. .....min.

9. Birthplace: Sumpter, S. Carolina
(Town, county, and state)

10. Usual occupation: Cannery

11. Industry or business

FATHER
12. Name: John Richardson
13. Birthplace: S. Carolina

MOTHER
14. Maiden name: Winther Cabbagesalto
15. Birthplace: S. Carolina

16. Informant: Deceased
Address

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof 10/10/47
(month) (day) (year)

Cemetery or crematory
Location: Sumter, S.C.

18. Funeral director: C. Hamp Keen
Address: Sykesville, Md

19. Oct. 7 19 47
(Date rec'd by registrar)
Albert R. Swanborne
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 19 47 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 19 47 to October 7 19 47 and that I last saw her alive on October 7 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben W. Isaac, M. D.
M. D. or other
Address: Henryton, Md. Date signed 10/7/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13C pa 08919

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 16 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1102 W. Fayette St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Fred Hazel Crockett

3.(b) Social Security Number: 218-01-4902

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	married

6.(b) Name of husband or wife: Carrie Crockett

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 1, 1896

8. AGE: Years	Months	Days	If less than one day
51	0	13	hrs. min.

9. Birthplace: Charlotte, N. Carolina
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business:

FATHER 12. Name: Henry Crockett

13. Birthplace: S. Carolina

MOTHER 14. Maiden name: Lula Neal

15. Birthplace: S. Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 (month) 18 (day) 47 (year)

Cemetery or crematory: Mount Auburn

Location: Baltimore MD

18. Funeral director: Katie R. Williams

Address: 3222 Edmondson

19. Oct. 14 (Date rec'd by registrar) 19 47 Albert R. Swankhan Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14 19 47 at 3:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 19 47 to October 14 19 47 and that I last saw h... im alive on October 14 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Foman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 10/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

08920

CERTIFICATE OF DEATH

Reg. Diat. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Carrie M. Crouse

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: John W. Crouse
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Dec. 28, 1870

8. AGE:

Years	Months	Days	If less than one day
76	9	20	...hrs. ...min.

9. Birthplace: Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John L. Long
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emily Gilbert
15. Birthplace: Maryland

16. Informant: John W. Crouse
Address: Mt. Airy, Md.

17. (Burial, ~~cremation, or removal. Which?~~) Burial
Date thereof 10-20-47 (month) (day) (year)
Cemetery ~~or crematory~~: Pine Grove
Location: Mt. Airy, Maryland

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. (Date rec'd by registrar) Oct 20 1947 Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 19 47, at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5, 1947 to Oct. 18 1947 and that I last saw him alive on Oct. 15 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	13 da
Due to Hypertension	? yrs
Due to Arterio-sclerosis	? yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt Airy - Md. Date signed: 10/19/47

9528

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2yrs. 6 mos. 13 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1623 East Eager Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frank Henry Curley

3.(b) Social Security Number: 215-12-5408

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Elaine Curley

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): June 27, 1922

8. AGE: Years	Months	Days	If less than one day
25	3	18	....hrs. ....min.

9. Birthplace: Newport News, Virginia
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER
12. Name: Thomas Curley
13. Birthplace: Newport News, Virginia

MOTHER
14. Maiden name: Magnolia Hill
15. Birthplace: Newport News, Virginia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 18 1947 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: annapolis Road

18. Funeral director: Mrs Robert Elliott & daughter

Address: 1129 N. Caroline St

19. Oct. 15 1947 (Date rec'd by registrar) Albert M. Lowenthal Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: October 15 1947 at 5:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1945 to Oct 15 1947 and that I last saw h im alive on October 15 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 8 1941
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Foreman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 10/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15


RECEIVED
OCT 16 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08321

47d / SC

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Springfield State Hospital (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 16 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 215 Dickeman St. (If rural, give LOCATION)

2.(a) If veteran, name war: /

3. (a) FULL NAME Samuel Thomas Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Jeannie Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9-26-85

8. AGE: Years	Months	Days	If less than one day
61	1		..... hrs. ..... min.

9. Birthplace: Martinsburg, W. Va. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: James H. Davis

FATHER 13. Birthplace: Martinsburg, W. Va.

MOTHER 14. Maiden name: Catherine Davis

MOTHER 15. Birthplace: W. Va.

16. Informant: Hospital records. Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29/47 (month) (day) (year)

Cemetery or crematory: Glen Haven Cemetery

Location: Ritchie Highway

18. Funeral director: Krause Funeral Home

Address: 216 S. Charles St.

19. Oct 28 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26, 1947, at 6:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10, 1947, to Oct. 26, 1947

and that I last saw him alive on June 10, 1947

	DURATION
Immediate cause of death: Carcinoma of right lung	4 mos.
Due to: Chronic Alcoholism	30 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed 10/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 BC 08922

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore- 17-
(If outside city or town limits, write RURAL and give nearest town)
Street No. 822 Woodyear Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ANDREW ROOSEVELT DORSEY

3.(b) Social Security Number: 218-12-7191

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown- 1907

8. AGE: Years	Months	Days	If less than one day
40	?	?	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof 10/11/47 (month) (day) (year)
Cemetery or crematory: Baltimore City Morgue.
Location:

18. Funeral director: Jos. O. Frankey & A. Hemsley.
Address: 519 W. Biddle St.

19. October 8, 19 47 (Date rec'd by registrar) Albert R. Swarbaugh Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 19 47 at 6:15-A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17 19 47 to Oct. 8 19 47 and that I last saw him alive on October 8 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Lucas M.D. M. D. or other
Address: Henryton, Md. Date signed 10-8-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

18923

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 3 mos. 8 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored, Branch
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 831 South Boyd St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles Calvert Edwards

3.(b) Social Security Number: 220-14-5863

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21, 1925

8. AGE: Years	Months	Days	If less than one day
22	7	2	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Charles Edwards
13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Gladys Ruffins
15. Birthplace: Baltimore, Maryland
16. Informant: Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 27-1947 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cem
Location: Baltimore, Md
18. Funeral director: Elroy O. Wilson
Address: 1000 Beanty, ave
19. October 23 19 47 (Date rec'd by registrar) Albert R. Swanhaus Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 19 47 at 5:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 46 to Oct. 23 19 47 and that I last saw him alive on October 23 19 47

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	July 4th 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 10/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

17a 08924

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years, 6 months, 1 day

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 12 years, 6 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Ida Farris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Frank Farris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 24, 1872

8. AGE: Years	Months	Days	If less than one day
75	8	2	..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Joseph Noel

13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Margarite Abell

15. Birthplace: West Virginia

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 27 47 (month) (day) (year)

Cemetery or crematory: Meadow Ridge Cemetery

Location: Washington Rd - Elkridge Md

18. Funeral director: Frank H. Purnell

Address: Pikesville, Md.

19. Oct. 26 1947 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25, 1947 at 5.50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to October 25 1947 and that I last saw her alive on October 25, 1947

Immediate cause of death	DURATION
Tuberculosis of the bone	
(right femur) about	6 months
Due to	
Due to	
Other conditions: Involutional melancholia	13 years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Irma H. Hedeman M.D. (M. D. or other)

Address: Springfield State Hospital Date signed: 10-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08925

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 1 mo. 4 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Huntsville,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Augustus Ellsworth Ford

3.(b) Social Security Number: 216-12-4594

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 10, 1923

8. AGE: Years	Months	Days	If less than one day
23	11	6	hrs. min.

9. Birthplace: Huntsville, Md. (Town, county, and state)
10. Usual occupation: Electric Truck Operator
11. Industry or business

FATHER
12. Name: Benjamin Ford
13. Birthplace: Maryland

MOTHER
14. Maiden name: Gertrude Queen
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/19/47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cem
Location: District of Columbia
18. Funeral director: Robinson Co.
Address: 1313-6 St. N.W. Wash. D.C.

19. October 16 19 47 (Date rec'd by registrar) Albert R. Swanhaus Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: October 16 19 47 at 11:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 12 19 44, to October 16, 47 and that I last saw him alive on October 16 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 10/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

not to be 83a 08926

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Mt Airy (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Frederick
City or town Emmitsburg Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James E. Grimes

3.(b) Social Security Number 215-20-9121

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Effie S. Grimes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1876

8. AGE: Years 71 | Months 0 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
12. Name Chas S Grimes
13. Birthplace Md
14. Maiden name Rachael Warfield
15. Birthplace Md

16. Informant Robert Grimes
Address Emmitsburg Md

17. Burial Date thereof Oct 9, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rosedale
Location Rosedale Md

18. Funeral director C. D. Thurston
Address Emmitsburg Md

19. Oct 7 1947 John D Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1947 at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 1947 to Oct 7 1947
and that I last saw him alive on Oct 7, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Arterio sclerosis and Hypertension	? yrs
Due to	
Other conditions Bronchial Asthma	? yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. or other
Address Emmitsburg Md Date signed 10/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 175a

08927

CERTIFICATE OF DEATH

Reg. Diat. No. 81

1. PLACE OF DEATH:
County: Carroll
City or town: Keymar Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Middleburg
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Keymar Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Middleburg
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Joshua C. Grossnickle

3.(b) Social Security Number: 218-05-0869

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mamie Kauffman

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 24 - 1892

8. AGE: Years: 55 | Months: 6 | Days: 17 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Frederick County, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Tillman Grossnickle
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Carmack
15. Birthplace: Maryland

16. Informant: Mrs. Mamie Grossnickle
Address: Keymar R. D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14-1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Washington, D. C.

18. Funeral director: W. H. Harbaugh & Sons
Address: Union Bridge & New Windsor, Md

19. Oct. 13 1947 (Date rec'd by registrar) Registrar: Eichman Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1947 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__
and that I last saw h alive on ____ 19__

Immediate cause of death	DURATION
Suffocation	
Due to: Compression of Chest	
Due to: Tractor accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 10-11-47
Where did injury occur? Middleburg (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where): Stone Farm
Means of injury: Tractor accident Injured at work? Yes

23. SIGNATURE: James T. Marsh Deputy Med. Examiner
M. D. or other
Address: Westminster Md Date signed: 10/13/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08928

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural-Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 Years

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 33 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1928 Walbrook Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GRANVILLE HAINES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1891

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	1	6		

9. Birthplace: Baltimore City, Maryland (town, county, and state)

10. Usual occupation: Physician

11. Industry or business:

FATHER
12. Name: Marshall Haines
13. Birthplace: Carroll Co, Md

MOTHER
14. Maiden name: Clara May Greenfield
15. Birthplace: Baltimore Co. Md.

16. Informant: Mrs Marshall Haines, Mother (Deceased)
Address: 1928 Walbrook Ave. Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 Oct 47 (month) (day) (year)

Cemetery or crematory: Hospital Cemetary

Location: Springfield State Hospital

18. Funeral director: C. Harry Klee

Address: Sykesville, Md.

19. Oct. 10 1947 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 Oct 47 19..... at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 July 47 19..... to 9 Oct 19 47 and that I last saw him alive on 9 Oct 47 19.....

Immediate cause of death	DURATION
Chronic myocarditid and myocardial degeneration.	2 Months.
Due to:	
Due to:	
Other conditions: Dementia praecox	33 Years.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: MARTIN GROSS. Martin Gross M. D.
M. D. or other

Address: Sykesville, Md Date signed: 10-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08929

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CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Central Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Audrey Laymonde Harp

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 14, 1899

8. AGE: Years: 48 | Months: 1 | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business:

FATHER
12. Name: Daniel J. Harp
13. Birthplace: Md.

MOTHER
14. Malden name: Blanche M. Johnson
15. Birthplace: Md.

16. Informant: Mrs. Mildred Arrington
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 19 1947 (month) (day) (year)

Cemetery or crematory: Mt. View Cemetery

Location: Howard Co., Md.

18. Funeral director: C. Henry Wees

Address: Sykesville, Md.

19. Oct 17 1947 (Date rec'd by registrar) C. Henry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 1947, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 1947 to Oct. 16, 1947 and that I last saw her alive on Oct. 15, 1947

Immediate cause of death	DURATION
Coronary thrombosis	
A	
Due Cardio Vascular Disease	
Due to	
Other conditions Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thos E. Martin M. D. or other

Address: Randallstown, Md. Date signed: 10/17/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

14 BC 08930

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 216 Aisquith St.
(If rural, give LOCATION)
2.(a) If veteran, name war J

3.(a) FULL NAME: Jeremiah Heath Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1946

8. AGE: Years	Months	Days	If less than one day
1	2	22	hrs. min.

9. Birthplace Warren, Georgia
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Jeremiah Heath Sr.

13. Birthplace Warren, Georgia

MOTHER 14. Maiden name Rosa Pearl Lee

15. Birthplace Warren, Georgia

16. Informant Mother- Rosa Pearl Heath

Address 216 Aisquith St. Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/13/47 (month) (day) (year)

Cemetery or crematory Mt. Calvary Cem

Location

18. Funeral director Elroy Wilson

Address 1800 Brandy ave.

19. Oct. 11 19 47 (Date rec'd by registrar) Albert R. Grantham Local Deputy Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH October 11 19 47 at 6:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15 19 47 to October 11 19 47 and that I last saw him alive on October 11 19 47

	DURATION
Immediate cause of death: Tuberculous Meningitis	9-22-47
Due to: Primary tuberculosis	7-14-47
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Nathan H. Foreman M.D.
M. D. or other

Address Henryton, Md. Date signed 10/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 08931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1402 Argyle Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: NATHANIEL CHARLES JOYNER

3.(b) Social Security Number: 219-22-9537

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth data of deceased (mo., day, yr.): December 15, 1927

8. AGE: Years	Months	Days	If less than one day
19	10	15	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business:

FATHER
12. Name: Charles Joyner
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Frances Barnett
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Frances Joyner
Address: 1402 Argyle Ave. Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/2/47 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location:

18. Funeral director: Wm. Chas. A. Stallings
Address: 1631 Druid Hill Ave.

19. 10/30 (Date rec'd by registrar) 19 47 Albert R. Swarbrick Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30, 1947, at 1.55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 1947, to Oct., 30, 1947 and that I last saw him alive on October 30, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 4, 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Nelson W. Bruans M.D.
M. D. or other

Address: Henryton, Md. Date signed: 10/30/47

08932

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name of hospital or institution. MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: E. Green

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles Koons

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Ellen R. Koons

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): March 20 - 1868

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78 ~~76~~	~~5~~ 6	13		

9. Birthplace: Patapsco, Carroll Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Edward E. Koons

13. Birthplace: Carroll Co. Md.

MOTHER 14. Maiden name: Elizabeth Mikesell

15. Birthplace: Carroll Co. Md.

16. Informant: Mr. Charles Mott

Address: Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 6 1947 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: H. Bankard & Son

Address: Westminster, Md.

19. (Date rec'd by registrar) 1947 E. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3 1947 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 3 1947 to October 3 1947 and that I last saw him alive on October 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: Sept 24 47

Due to: Arteriosclerosis, Hypertension & Myocardial Degeneration

Due to:

Other conditions: Prostatic Hypertrophy, 2 Previous Cerebral Hemorrhages

(Include pregnancy within 3 months of death)

Major findings of operations: (37)

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Nature of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other

Address: Westminster Md. Date signed: 10/3/47

08933

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

938

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Md - (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs. - 4 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville, Md - (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Annie Ernestine Kraft

3.(b) Social Security Number

4. Sex	5. Color or rece	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry John Kraft

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 24 - 1864

8. AGE: Years	Months	Days	If less than one day
83	1	20	..... hrs. ..... min.

9. Birthplace: Oella - Baltimore County (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Henry Engle

13. Birthplace: Germany

MOTHER 14. Maiden name: Annie Ernestine Spurrman

15. Birthplace: Germany

16. Informant: Mrs. Joseph Tomlinson

Address: Sykesville, Md -

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14, 1947 (month) (day) (year)

Cemetery or crematory: St. Johns Cemetery

Location: Ellicott City, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Oct. 13 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1947 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946, to October 12 1947

and that I last saw her alive on October 3 1947

Immediate cause of death	DURATION
Chronic Myocarditis and	5 years
Myocardial Degeneration	
Due to: Arteriosclerosis	5 years
Due to:	
Other conditions:	

(Includs pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

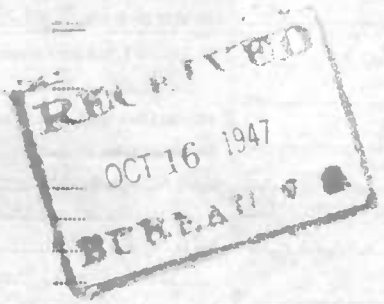
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. - M. D. or other

Address: Sykesville, Md Date signed: Oct. 12-'47


OCT 16 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08934

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city of town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 14 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or Institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Adamstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Robert Lee

3.(b) Social Security Number: 217-01-5876

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	married

6.(b) Name of husband or wife: Ella M. Lee
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 15, 1893

8. AGE: Years	Months	Days	If less than one day
54.		7	..... hrs. ..... min.

9. Birthplace: Adamstown, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: John A. Lee
13. Birthplace: Clarksburg, Md.

MOTHER
14. Maiden name: Annie Gibson
15. Birthplace: Adamstown, Md.

16. Informant: Dedeased
Address

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 10/25/47 (month) (day) (year)
Cemetery or crematory: Hopehill
Location: near Buckeystown
18. Funeral director: M. P. Etchison & Son
Address: 106 East Church St Frederick Md.

19. Oct. 22 1947 (Date rec'd by registrar) Albert R. Grandstaff Registrar
Local Deputy

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: October 22 19 47 at 5:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 8 19 47 to October 22 19 47 and that I last saw him alive on October 22 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Nicholas Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed 10/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

08935

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 11 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -------

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3820 Milford Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3.(a) FULL NAME: Emily J. Litchfield

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: D. Litchfield

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): October 20, 1879

8. AGE: Years	Months	Days	If less than one day
67	11	22	....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: James E. Logan

13. Birthplace: Maryland

MOTHER 14. Maiden name: Anna Lowman

15. Birthplace: Maryland

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal? Which?) Date thereof Oct 15-47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Frederick Rd

18. Funeral director: Waesche Cook Inc

Address: 1217 St Paul St

19. Oct 12 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1947, at 12:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1941, to Oct. 12 1947 and that I last saw her alive on October 12 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 hrs.
Due to: Arteriosclerosis	unkn.
Due to:	
Other conditions: Schizophrenia, Paranoid type	28 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other

Address: S.S.H. Sykesville, Md. Date signed: 10-12-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08936

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 306 Pearl Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rollin Mack

3.(b) Social Security Number: 251-18-9090

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	married

6.(b) Name of husband or wife: Mamie Mack
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 3, 1915

8. AGE: Years	Months	Days	If less than one day
32	6	12	hrs. min.

9. Birthplace: Sumter, S. Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: William Mack
13. Birthplace: Lee Co. S. Carolina

MOTHER
14. Maiden name: Rosa Binds[illegible]er
15. Birthplace: Lee Co. S. Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 19, 1947 (month) (day) (year)
Cemetery or crematory: Pine Grove Cem.
Location: Sumter S. Carolinia

18. Funeral director: Elroy O. Wilson
Address: 1000 Bellamy ave

19. October 15, 47 (Date rec'd by registrar) Albert R. Smallwood Registrar
Local Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 1947 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15 1947 to October 15 1947 and that I last saw him alive on October 15 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1st 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Fraser, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 10/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08937

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

James Marshall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 28, 1897

8. AGE: Years	Months	Days	If less than one day
50	1	18	hrs. min.

9. Birthplace: Severn, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: James Marshall

13. Birthplace: Unknown

MOTHER 14. Maiden name: Margaret Queen

15. Birthplace: Unknown

16. Informant: Sister: Miss Louise Marshall

Address: Severn, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 20-47 (month) (day) (year)

Cemetery or crematory St. Marks Ch

Location a.a.co md

18. Funeral director James A Hayes

Address 1,42 west St. Balto. md

19. October 16 19 47 (Date rec'd by registrar) Albert R. Smith Registrar
Local Deputy

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: October 16 19 47 at 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9 19 47 to October 16 19 47 and that I last saw him alive on October 16 19 47

Immediate cause of death	DURATION
Tuberculous Meningitis	10/8/47
Due to: Pulmonary Tuberculosis	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben W Ruan, M.D.
M. D. or other

Address Henryton, Md. Date signed 10/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830

08938

Reg. Diat. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Carroll

City or town: New Windsor Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nettie G. Murdock

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 5 - 1885

8. AGE: Years 61 | Months 11 | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace Carroll County Md (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business At home

FATHER 12. Name Simon P. Murdock

13. Birthplace Maryland

MOTHER 14. Maiden name Cecelia Chambers

15. Birthplace Maryland

16. Informant Lettie R. Flowers

Address New Windsor R. D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4 - 1947 (month) (day) (year)

Cemetery or crematory Fairview Cemetery

Location Near Taylorsville, Md.

18. Funeral director H. H. Hartzler & Sons

Address Union Bridge & New Windsor Md.

19. Nov 1 1947 (Date rec'd by registrar) Ernie S Bunder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1947 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to Oct 31 1947 and that I last saw h.e.r. alive on Oct. 31 1947

Immediate cause of death: Cerebral hemorrhage — DURATION 24 hrs +

Due to: arteriosclerosis — indefinite

Due to: Hemiplegia due to previous cerebral hemorrhage — 5 mos

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE C Reese Willsen M.D.

M. D. or other

Address Westminster Date signed Nov. 1 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08939

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Mt. Gilboa

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Mt. Gilboa

(If outside city or town limits, write RURAL and give nearest town)

Street No. Sykesville P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Ellen Noyes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife James B. Noyes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1893

8. AGE: Years	Months	Days	If less than one day
54	9	0	..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER

12. Name John A. Ware

13. Birthplace Balto Co Md

MOTHER

14. Maiden name Margaret E. Richardson

15. Birthplace Howard Co Md.

16. Informant Mr. James B. Noyes

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Nov 2, 1947 (month) (day) (year)

Cemetery or crematory Bridgehill Cemetery

Location Sykesville, Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. Oct 31 1947 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1947 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary artery disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

..... Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE James T. Hart D Deputy Medical Examiner
M. D. or other

Address Westminster Md. Date signed Oct 31-1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 yrs 9 mo 2 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 39 yrs 9 mo 2 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore Co.

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Michael Quint (Quinn)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years: 54 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER — 12. Name: Andrew J. Quint

13. Birthplace: Md.

MOTHER — 14. Maiden name: Estella A. Quint

15. Birthplace: Md.

16. Informant: Mrs. Katie Akers

Address: 1330 Riggs Ave Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-10-47 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Baltimore Md.

18. Funeral director: A. Wilbur Cook Inc.

Address: 1217 St Paul St.

19. Oct 8 1947 (Date rec'd by registrar) C. Harry Eberly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7th 1947, at 1-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 7th 1946 to Oct 7th 1947 and that I last saw h alive on Oct 7th 1947

	DURATION
Immediate cause of death:	
Coronary Thrombosis	1 hr
Due to: Lobar Pneumonia	3 da
Due to:	
Other conditions: Epilepsy	48 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. A. Hastings M.D. M. D. or other

Address: Sykesville Md. Date signed: 10/7/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08941

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Beatrice Redmon

3.(b) Social Security Number None

4. Sex: Female
5. Color or race: colored
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband ~~or wife~~: Henry Redmon
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 7-1895
8. AGE: Years 52 Months 2 Days 2 If less than one day ..... hrs. ..... min.
9. Birthplace: Frederick County, Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Luther Hayes
13. Birthplace: Maryland
MOTHER 14. Maiden name: Rebecca Murdock
15. Birthplace: Maryland
16. Informant: Henry Redmon
Address: New Windsor, Md. R. D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 12-47 (month) (day) (year)
Cemetery or crematory: Mt. Olive Cemetery
Location: Frederick County, Md.
18. Funeral director: H. H. Hartle & Sons
Address: Union Bridge & New Windsor, Md
19. Oct 11-1947 (Date rec'd by registrar) Emma B. Reinhardt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1947 at 6:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to Oct 9 1947 and that I last saw h er alive on Oct 2 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE J. N. Legg M. D. or other
Address Union Bridge Date signed 10-10-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47c / BC 08342

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Springfield State Hospital (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs., 3 mos., 5 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 35 yrs., 3 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1415 Belt St. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William E. Rehling

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1889

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace: Baltimore City, Md. (Town, county, and state)

10. Usual occupation: Jeweler

11. Industry or business:

FATHER — 12. Name: Henry E. Rehling

13. Birthplace: Md.

MOTHER — 14. Maiden name: Annie M. Temple

15. Birthplace: Md.

16. Informant: Hospital records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-31-47 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore Md.

18. Funeral director: G Howard Strong

Address: 3207 W. North Ave.

19. Oct 29 1947 (Date rec'd by registrar) C. Harry Zilker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28, 1947 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1947, to Oct. 28, 1947

and that I last saw him alive on Oct. 28, 1947

Immediate cause of death	DURATION
Anaplastic Carcinoma of right bronchus	2 mos
Due to	
Due to	
Other conditions: Schizophrenia	35 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Bronchoscopy: Cauliflower growth, right bronchus, close to bifurcation of trachea Date of op. 10/12/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 10/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

08943

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 8 months, 30 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 3 years, 8 months, 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2703 Ulman Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: /

3.(a) FULL NAME: Regina Kors Rosenthal

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 10, 1877

8. AGE: Years	Months	Days	If less than one day
70	6	21	..... hrs. ..... min.

9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: Moses Kors
13. Birthplace: Austria

MOTHER
14. Maiden name: Mollie unknown
15. Birthplace: Austria

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-3-47 (month) (day) (year)
Cemetery or crematory: Balto. Md.
Location: Hebrew Friendship Cem.
18. Funeral director: Jack Lewis & Sons
Address: 400 Eutaw Place
19. Nov 1 1947 (Date rec'd by registrar) C. Henry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31, 1947 at 8.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 1944, to October 31 1947 and that I last saw her alive on October 31, 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	4 hours
Due to: arteriosclerosis about	8 years
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	7 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hohman, M.D. M. D. or other
Address: Springfield State Hospital Date signed: 10-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

08948

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years, 4 months, 6 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 11 years, 4 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore Co
City or town: White Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Anna Sadler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: John W. Sadler
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1906 month and day unknown

8. AGE: Years	Months	Days	If less than one day
41	unknown		..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business:

FATHER
12. Name: Hartman
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Wertz
15. Birthplace: Pennsylvania

16. Informant: Hospital record
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 13 1947 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.

18. Funeral director: C. Harry Wees
Address: Sykesville, Md.

19. Oct 13 1947 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10, 1947 at 2.30p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1, 1942, to October 10, 1947
and that I last saw her alive on October 10, 1947

Immediate cause of death	DURATION
Cancer of the left breast	10 months
with	
Abdominal metastases	
Due to:	
Other conditions: Schizophrenia, paranoid type	about 11 years

(Include pregnancy within 3 months of death)

Major findings of operations: Scirrhous carcinoma of the left breast Date of op. 2-6-1947

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Irene H. Lehmann, M.D. (M. D. or other)
Address: Springfield State Hospital Date signed: 10-10-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48 b / 08944 81

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll Co

City or town: Union Bridge Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.: South Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME: Lelah Margaret Saylor

3. (b) Social Security Number: ----------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 24 - 1886

8. AGE: Years: 60 | Months: 9 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick Co (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business .....

FATHER — 12. Name: S. Albert Saylor

FATHER — 13. Birthplace: Frederick Co. Md

MOTHER — 14. Maiden name: Susan Hoffman

MOTHER — 15. Birthplace: Md

16. Informant: Howard Myers

Address: Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 28-47 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Near New Windsor Md

18. Funeral director: Raymond K Wright

Address: Union Bridge Md

19. Oct 27 47 (Date rec'd by registrar) 19.. Jesse D. Pepple Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1947 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 1947 to Oct 28 1947 and that I last saw her alive on Oct 28 1947

Immediate cause of death	DURATION
Carcinoma	
Uterus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: Oct 27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08945

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years, 3 months, 1 day

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 16 years, 3 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Roxie Catherine Shrader

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	divorced

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1870, date unknown

8. AGE: Years	Months	Days	If less than one day
77	unknown		..... hrs. ..... min.

9. Birthplace: Greencastle, Pennsylvania (Town, county, and state)

10. Usual occupation: seamstress

11. Industry or business:

FATHER — 12. Name: William Shrader

13. Birthplace: Greencastle, Pennsylvania

MOTHER — 14. Maiden name: Martha Nipple

15. Birthplace: Greencastle, Pennsylvania

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-4-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Ametery

Location: Hagerstown Md

18. Funeral director: Kath F Minnick & Son

Address: Hagerstown Md

19. Oct 2 1947 C. Harry Weed

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1, 1947 at 5.05a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1942, to September 30, 1947

and that I last saw her alive on September 30, 1947

Immediate cause of death		DURATION
Chronic myocarditis and myocardial degeneration	about	8 years
Due to: arteriosclerosis	about	16 years
Due to:		
Other conditions: schizophrenia, paranoid type	about	30 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Irene H Lehmeier, M.D

M. D. or other

Address: Springfield State Hospital Date signed: 10-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1860

08946

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months, 13 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or Institution? 9 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Olney

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknwon

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Clara Spates

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 2, 1864

8. AGE: Years	Months	Days	If less than one day
83	3	7	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Franklyn Bready

13. Birthplace: unknown

MOTHER — 14. Maiden name: Octavia Henrietta Cushell

15. Birthplace: unknown

16. Informant: Hospital record

Address: Springfield State Hospital

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-10-47 (month) (day) (year)

Cemetery or crematory:

Location: Bethesda, Md

18. Funeral director: Wm B Brighey

Address: Bethesda, Md

19. Oct 10 1947 (Date rec'd by registrar) C. Henry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1947 at 10.45p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1947, to October 9 1947

and that I last saw her alive on October 9, 1947

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	about 1 year
Due to: arteriosclerosis	several years
xx fracture of left femur	1 month
Other conditions: Senile psychosis, simple deterioration	about 2 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9/8/47

Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Hospital

Means of injury: Slipped & fell while going Injured at work? bathroom. 11/25/47 DS.

23. SIGNATURE: Irene Hochmuth, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 10-9-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 08947

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 70 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lizzie I. Stone

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Harvey A. Stone

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 19, 1863

8. AGE: Years	Months	Days	If less than one day
83	10	14	..... hrs. ..... min.

9. Birthplace: Westminster, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Elijah Wagoner

13. Birthplace: Maryland

MOTHER 14. Maiden name: Rebecca Werble

15. Birthplace: Maryland

16. Informant: Mrs. William Helm

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/6/47 (month) (day) (year)

Cemetery or crematory: Krider's Cemetery

Location: near Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 10/4 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3 1947, at 2½a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 25 1947, to Oct 3. 1947, and that I last saw her alive on Oct 2. 1947

Immediate cause of death	DURATION
acute Cardiac Dilatation —	18 hrs
Due to Chronic myo-cardites —	2 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. R. Fouty M.D. M. D. or other

Address: Westminster Md. Date signed 10.3.47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08949

CERTIFICATE OF DEATH

Reg. Dist. No. 79

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Rural - Keysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural - Keysville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Grim Stonesifer

3. (b) Social Security Number none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: C. Gordon Stonesifer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 21, 1881

8. AGE: Years 66 | Months 1 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace: New Midway, Frederick Co. Md. (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: own home

FATHER

12. Name: Joseph Grim

13. Birthplace: Penna.

MOTHER

14. Maiden name: Mary Eyler

15. Birthplace: Maryland

16. Informant: Mr Clarence Stonesifer

Address: Keymar, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 4, 1947 (month) (day) (year)

Cemetery or crematory: Keysville Cemetery

Location: Keysville, Md.

18. Funeral director: C. O. Fuss & Son

Address: Taneytown, Md.

19. Oct. 2 1947 (Date rec'd by registrar) Jamey M. Kiser Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 1 1947 at 7 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 1947 to Oct. 1 1947 and that I last saw h[illegible] alive on 9/26 1947

Immediate cause of death	DURATION
Coronary Artery Occlusion	Few Minutes
Due to: Coronary Sclerosis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. S. McVaugh M.D. M. D. or other

Address Taneytown, Md. Date signed 10/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Diat. No. 68950

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs 5 mos 20 da
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 5 yrs 5 mos 20 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war J

3.(a) FULL NAME Catherine Fellers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Robert Fellers
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 2d 1866

8. AGE: Years 69 | Months 3 | Days 15 | If less than one day ____ hrs. ____ min.

9. Birthplace Md (Town, County, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER 12. Name Adam Seifert
13. Birthplace Md

MOTHER 14. Maiden name Catherine Stumpfaer
15. Birthplace Md

16. Informant Mrs Catherine Seifert
Address 2518 Orleans St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23 1947 (month) (day) (year)
Cemetery or crematory Lakewood Cemetery
Location Balto Md

18. Funeral director John Ullrich
Address 2018 Orleans St. Balto Md

19. Oct. 21 1947 (Date rec'd by registrar) C. Henry Wehr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21st 1947 at 4-23 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30th 1942 to Oct 21 1947
and that I last saw h... alive on Oct 21 1947

	DURATION
Immediate cause of death	
Cerebral Hemmorage	4 da
Due to	
Huntington Chorea	18 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:-
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE W. H. Haston M.D. M. D. or other
Address Sykesville Md Date signed 10-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 b Be 08951

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1yr., 6mons., 11days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore 30
(If outside city or town limits, write RURAL and give nearest town)
Street No. 136 W. West Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
FLORINE VANLANDINGHAM

3.(b) Social Security Number

4. Sex	5. Color or race	B.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: William Vanlandingham
6.(c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.) May 11, 1927

8. AGE: Years	Months	Days	If less than one day
20	4	22	..... hrs. ..... min.

9. Birthplace Salisbury, Maryland
(Town, county, and state)
10. Usual occupation Factory Worker
11. Industry or business

FATHER
12. Name Henry Johnson
13. Birthplace Salisbury, Maryland

MOTHER
14. Maiden name Margaret Smoot
15. Birthplace Salisbury, Maryland

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 5 1947 (month) (day) (year)
Cemetery or crematory Mt Calvary
Location A. B. C. Rd Md
18. Funeral director David L Brown Jr
Address 108 W Montgomery St

19. October 3, 19 47 (Date rec'd by registrar) Albert R Frankhauser Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1947 at 4:30A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1946, to Oct. 3, 1947 and that I last saw her alive on October 3, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1946
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W Swan, M. D.
M. D., or other
Address Henryton, Maryland Date signed 10-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

08952

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

Reg. Diat. No. 71

1. PLACE OF DEATH:

County Carroll

City or town Frizellburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 - 6 - 5

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Frizellburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lewis Daniel Grant Wantz

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Mary Alice Wantz

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) March 26 - 1870

8. AGE:

Years	Months	Days	If less than one day
77	6	5	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Grocer: Retired

11. Industry or business

FATHER

12. Name Lewis Wantz

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Margaret Stamer

15. Birthplace Carroll Co. Md.

16. Informant Wilbur Wantz

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 15 - 1947 (month) (day) (year)

Cemetery or crematory Meadowbranch Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. Oct. 15 - 19 47 Margaret R. Engler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 19 47 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 8 19 47 to October 11 19 47

and that I last saw him alive on October 11 19 47

Immediate cause of death	DURATION
(General) Arterio Sclerosis	
myocardial degeneration, Congestion & Edema	2 yrs. 2 wks.
Due to a ascites	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilbur Speicher M. D. or other

Address Westminster Md Date signed 10/13/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

104a 08953

CERTIFICATE OF DEATH

Reg. Diat. No. 81

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Austin Wayne Wetzel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, year): June 30 - 1947

8. AGE:

Years	Months	Days	If less than one day
	3	6	..... hrs. ..... min.

9. Birthplace: Carroll County, Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Truman W. Wetzel

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mildred M. Clemsons

15. Birthplace: Maryland

16. Informant: Truman W. Wetzel

Address: Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 7-1947 (month) (day) (year)

Cemetery or crematory: Evergreen Gardens

Location: Westminster, Md

18. Funeral director: H. H. Hartle & Sons

Address: Union Bridge & New Windsor Md.

19. Oct. 7 1947 (Date rec'd by registrar) J. Richardson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6 1947 at 5:30 A.M. (Prior to)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to Oct 6 1947

and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Suffocation	—
Upper Respiratory Infection	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James T. Marx County Medical Examiner M. D. or other

Address: Westminster Md Date signed: 10-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08954

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos. 10days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Marion ~~Marion~~
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 62
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Julia Elizabeth Whittington

3.(b) Social Security Number: 213-18-5197

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	married (Sep)

6.(b) Name of husband or wife: Robert Whittington

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): July 2, 1920

8. AGE: Years	Months	Days	If less than one day
27	3	9	....hrs. ....min.

9. Birthplace: Wenona, Maryland
(Town, county, and state)

10. Usual occupation: Beautician

11. Industry or business

FATHER — 12. Name: John Johnson

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sadie White

MOTHER — 15. Birthplace: Maryland

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: oct. 15. 1947 (month) (day) (year)

Cemetery or crematory: Marion Cem.

Location: Marion Md

18. Funeral director: Charlie Ward

Address: Marion Md

19. Oct. 11 (Date rec'd by registrar) 19 47 Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION

R.

20. DATE OF DEATH: October 11 19 47 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 19 47 to October 11 19 47 and that I last saw her alive on October 11 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 15 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paulus Hoffman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 10/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08955

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 7 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Waldorf (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HARRY WOOD, Jr.

3.(b) Social Security Number: 217-14-7570

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married (Seperated)

6.(b) Name of husband or wife: Audery Wood
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): November 31, 1919

8. AGE: Years	Months	Days	If less than one day
27	11	27	....hrs. ....min.

9. Birthplace: Waldorf, Md. (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business
FATHER 12. Name: Harry Wood Sr,
FATHER 13. Birthplace: Waldorf, Md.
MOTHER 14. Maiden name: Emma Makle Sr.
MOTHER 15. Birthplace: Waldorf, Md.
16. Informant: Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/30/47 (month) (day) (year)
Cemetery or crematory St. Peter's
Location Waldorf, Md
18. Funeral director Hunt & Ryon
Address Waldorf, Md.
19. 10/28 19 47 (Date rec'd by registrar) Albert R. Swanson Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 19 47 at 5.30 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 21 19 47 to Oct., 28, 19 47
and that I last saw h.... im alive on October 28, 19 47

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	July 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide.... Date of ....
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of Injury Injured at work?

23. SIGNATURE Reuben W. Kwan M.D. M. D. or other
Address Henryton, Md. Date signed 10/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1860 08956

Reg. Dist. No. 78

1. PLACE OF DEATH:
County: Carroll
City or town: near Winfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: near Winfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Westminster
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maura Yohn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Anna Mary Yohn
deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1863

8. AGE: Years	Months	Days	If less than one day
84	1	21	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Farmer retired
11. Industry or business

FATHER
12. Name: William Yohn
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Owings
15. Birthplace: Maryland

16. Informant: Mr. Merle Yohn
Address: Westminster, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 10-27-47 (month) (day) (year)
Cemetery ~~or crematory~~: St. James
Location: Dennings, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Oct. 26 (Date rec'd by registrar) 19 47 E M Farver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 19 47 at 10 a m

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ——— 19—, to ——— 19—
and that I last saw h— alive on ——— 19—

Immediate cause of death	DURATION
Fracture - dislocation 2nd Cervical Vertebra	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Oct. 25-47
Where did injury occur? Westminster (City or town) Carroll (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home -
Means of injury: Stumbled & fell Injured at work? no.

23. SIGNATURE: James T. Marsh Deputy Medical Examiner M. D. or other
Address: Westminster Md. Date signed 10-25-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08957

CERTIFICATE OF DEATH

Reg. Diat. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Melrose
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 90 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Melrose
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Edward Zepp

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Rebecca Shaffer Zepp (Deceased)
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): December 6, 1866
8. AGE: Years: 90 Months: 10 Days: 16 If less than one day: hrs. min.
9. Birthplace: Carroll Co. (Town, county, and state) Maryland
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: William Zepp
13. Birthplace: Unknown
MOTHER 14. Maiden name: Susan Sherman
15. Birthplace: Unknown
16. Informant: Edward Zepp Address: Manchester, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-25-47 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester, Md
18. Funeral director: Jacob Winter's Sons
Address: Manchester, Md.
19. Oct. 24 1947 (Date rec'd by registrar) Mrs. M. P. J. Demuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23, 1947, at 8:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1941, to Oct 23 1947
and that I last saw h— alive on Oct. 19 1947

Immediate cause of death	DURATION
Pneumonia, underlying cause: Arterio sclerosis	3 days
Due to: Asthma, chronic	10 yrs.
Due to: Cardiac Decompensation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Portnoff M. D. or other
Address: Hampstead, Md. Date signed: 10-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M